I put her on the bromide of quinin gr. 5 three times a day in pill form.

Specimen Presented. Mrs. Stevenson. 54 years of age. Widow. Two daughters. Husband died when she had been married only 4 years and she has worked very hard all her life to support herself and children. Some years ago she was told in Iowa that she had a fibroid of the uterus. A similar diagnosis was made in San Francisco.

On the 28th of August, while lifting a mattress, she felt a pain in her right iliac region. She had occasional spells during the day, and at three o'clock in the morning of the 29th was taken with a very severe pain and vomiting which continued. I saw her in the afternoon. There was marked tenderness in the lower abdomen, a palpable tumor exquisitely tender; still nauseated; no bowel movement; no temperature. She was removed to St. Mary's Hospital with a provisional diagnosis of a fibroid with a twisted pedicle.

Aug. 30th, operation: Before the peritoneum was opened, a dark mass was seen which on palpation fluctuated and the diagnosis was changed to strangulated ovarian cyst. There was some dark, free blood in the peritoneum; the cyst was lifted out entire; an intra-mural fibroid was found in the uterus, and as on palpation a polyp had been felt projecting from the cervix, a complete hysterectomy was performed.

Patient was up on the 10th day and left the hospital on the 14th day.

On splitting the uterus its cavity was found to be filled by a polyp whose pedicle was attached to the fundus.

Mr. G. U. Patrick. Was seen by me in consultation with Dr. R. J. Nicholls on July 29, 1911. Patient is 38 years of age; a miner; married; no children. His father was killed in a mine at the age of 42. His mother died at the age of 22 in confinement. No brothers or sisters. The only sickness he remembers before the present trouble was ptomaine poisoning from shrimp salad in January, 1910. He was very sick for one night and had bowel disturbance until July, 1910.

His present trouble started in December, 1910. He never had a diarrhea, never had dysentery or typhoid fever. Severe pains and constipation began in March, 1911. He complained that riding in a buggy or a car brought on attacks of pain in the right side. These lasted for an hour or two and then disappeared under massage. These attacks occasionally occurred without any exciting cause. He found that when these attacks were on a lump formed in the right iliac region, which disappeared on rubbing.

On examination this phenomenon was observed; a mass forming in the right iliac region, but also in the right hypochondriac following usually the disappearance of the former. He was sent to the German Hospital, the lower bowel inflated, and it was found that the abdominal cavity below and to the left of a line drawn from the tip of the left 8th rib to the right anterior superior spine of the ilium, became inflated and produced pain. From that we concluded that the transverse colon was attached somewhere in the right iliac region. Gastric analysis gave the results usually accompanying carcinoma of the stomach with the exception of the absence of blood. A series of X-ray pictures, taken after the ingestion of bismuth gruel, showed that there was an obstruction on the right side, where the bismuth was partly retained.

August 3d, operation: An incision was made in the outer border of the right rectus muscle; a small, hard mass was palpated, not very movable owing to adhesions passing across the transverse colon. These were liberated and the proximal end of the colon was so distended and thickened as to resemble the stomach. The appendix was very long and distended with fecal matter, evidently due to backward pressure. The mass in the transverse colon was resected; the two ends brought together with large Murphy button.

The lymphnodes attached to the mass were sent to Prof. Ophuls, who reported no tumor; diagnosis—catarrhal lymph-adenitis. The piece of bowel was then submitted for examination and the report came carcinomatous ulcer of the colon.

Patient developed an ether pneumonia but responded promptly to a few hypodermics of digalen.

On the 9th day patient was up.

On the 11th day a Roentgen picture revealed the Murphy button still in situ, and the patient left the hospital.

On the 14th day patient came to the office complaining that his hemorrhoids bothered him. He was given some ointment and told to use cold applications. He returned the following day with the statement that there was an obstruction in the lower rectum. It proved to be the Murphy button, which required removal by forceps.

A letter from Dutch Flat, dated September 2nd, states that the patient is feeling splendidly, has gained 7 pounds, but still takes a little cascara every night for his bowels.

Surgical Section, Sept. 19, 1911.

By JNO. C. NEWTON, M. D., San Francisco.

This is a case of external anthrax. We know that the anthrax bacillus is of special historical interest on account of its being the first micro organism proved definitely to have a specific etiological relationship to an infectious disease. More animals (cattle and sheep) succumb to anthrax than of any of the other diseases affecting them.

This patient came in from the country this afternoon, complaining of swelling and stiffness of his hand and arm and the three pustules seen on his thumb and finger.

The history begins three days ago. The patient is a milker and gives the information that he had assisted in the burying of several cows that had died from some unknown cause. There were slight abrasions on his hand and from these places the condition seen here rapidly developed. His temperature is 101, pulse 112. The carbuncular lesions are capped with characteristic bluish vesicles.

The anthrax bacilli has been demonstrated in smears made from the Sero Sanguineous contents of the vesicles. In the case I previously presented to the society in Sept., '09, which is reported in the State Journal of Jan., 1910, the diagnosis was verified by guinea pig inoculation. I will treat this condition by injecting 0.35 of pure carbolic acid into each pustule and follow this by mild germicidal applications. He is receiving 0.35 each of guaiacol and quinin sulphate internally.

A vaccine will be used if the condition does not yield to this treatment. The prognosis is bad in all forms (Ravenel) and the mortality of external anthrax is variously given at from 5 to 25%. The pulmonary form (wool sorters' disease) is largely fatal.

On the Paralysis of the Abducens of Otitic Origin.*

By VICTOR F. LUCCHETTI, M. D., San Francisco.

At the last meeting of the Eye and Ear Section of the County Medical Society, an interesting case having a symptom complex known as Gradenigo's Syndrome was presented and discussed; and Dr. Welty, chairman of our section, requested me to make an extensive report on the above disease at this meeting. The condition is such a rare and interesting one to the specialist and profession at large from an anatomical and pathological standpoint, that I deemed it advisable to present in full the views of the author regarding this affection.

Prof. Gradenigo does not agree with Citelli that one should speak in a general way of Gradenigo's Syndrome; but rather of a well defined and pathological condition.

* Read before the Eye, Ear, Nose and Throat Section of the San Francisco County Medical Society, Sept. 26th, 1911.

In the beginning, owing to a lack of sufficient data, he was rather skeptical regarding the interpretation of this particular condition. Now, he is of the firm opinion that with the quantity of material gathered, the syndrome first described by him in acute otitis, and more rarely in the chronic forms with acute exacerbation; the disease is propagated by infection from the middle ear to the cells at the apex; particularly the peri-tubular cells. In some cases, the process is limited to an osteitis of the apex of the temporal bone, with a lesion of the abducens. It may involve the Gasserian ganglion and the fifth nerve, or it may give rise to symptoms of pachi-meningitis. Fortunately, although very rare, the infection passes by this means to the pia-mater, giving rise to a serous or purulent circumscribed or diffuse lepto-meningitis.

He says, therefore, that those who maintain that it is always a simple osteitis and not a pachi-meningitis, or lepto-meningitis are wrong. It is essentially one and the same process which permits you to observe in single cases the different stages of the infection, from the stage of invasion confined to the osseous cells, to the stage of extension to the meninges. He is also of the opinion that those who maintain that it is a reflex phenomenon, as well as those that think that the paralysis of the sixth nerve is due to an infectious thrombosis, or simply a periphlebitis propagated from the petrosal sinuses to the cavernous sinuses are wrong.

He also says that nothing is more misleading for the correct interpretation of clinical facts than to put together haphazardly as some authors have done, all the cases of abducens paralysis which appear during a course of otitis.

We know very well that this symptom can be found in many different pathological conditions, especially in diffuse purulent lepto-meningitis, specific lesions of the cranial contents, in deep extra dural abscesses of the superior border of the pyramid (apex), in diffuse osteomyelitis of the temporal bone, etc. The syndrome as expounded by Gradenigo is clinically constituted by three essential symptoms.

1. Acute purulent otitis media (and in rare cases), chronic.
2. Intense and persistent pains mostly localized to the temporal region, and in the orbit of the same side as the otitis.
3. The appearance from fifteen to twenty days from the beginning of the otitis, sometimes sooner, sometimes later, of an isolated paralysis of the abducens on the same side as the ear lesion.

Notwithstanding the fact that this condition is often complicated by manifest symptoms of mastoiditis, optic neuritis, neuralgia of the fifth nerve, etc., these complications do not change the pathological view of the disease in question.

The prognosis is considered favorable in most cases, the paralysis disappearing with a retrogression of the otitis and operation on the mastoid which must be thorough. It is graver when optic neuritis is present, as it signifies a diffusion of the process in the meninges.

Tuberculosis of the Uveal Tract, With Presentation of Case.*

By EDGAR W. ALEXANDER, San Francisco.

Since Sidney Stephenson and George Carpenter asserted in 1901 that tubercle of the choroid may be found in any stage and any kind of tuberculosis, many ophthalmologists have corroborated their statements and offered clinical proof of their truth.

The class of lesions, however, to which these authors have particular reference are very different from those formally described as tubercular, in fact none of the recent text books refer to them as such, even Axenfeld in his latest book nor Groenouw, who edited the section on tuberculosis of the choroid in the last edition of the Graefe-Saemisch Handbuch. It is on this account that I report to this section a case illustrative of this type which I have followed in the University of California Hospital, bearing in mind the recent literature on the subject.

A preliminary demonstration was made a few months ago when the eye was in an active state.

Tuberculosis of the choroid was formally considered to be associated only with grave lesions of the general system, such as disseminated miliary and meningeal tuberculosis, and to consist of the typical cellular formations with Langhan's giant cells, etc. On that account it was a rare disease and only those who had a service in a large general hospital had much of an opportunity of seeing it. However, with the introduction of modern methods of diagnosis, viz: Calmette, von Pirquet, Moro, subcutaneous tubercular reactions and Wassermann's test for syphilis we find that the percentage of recognized tubercular affections of the eye takes a big jump upwards and the diagnostic waste-baskets of congenital and syphalitic lesions are deprived of a large number of their contributions.

It is extremely difficult and often impossible to differentiate, without these tests, between terminal tubercular and syphilitic choroiditis as well as their active states, especially when we exclude the disseminated variety of the latter condition; and congenital lesions due to intra-uterine inflammation, and true colobomata are not always typical.

The text-books speak of a scattered solitary tubercle of the choroid, also the conglomerate vaviety, and mention is made in the literature of "obsolescent" tubercle occurring with clear mediae; but the type of which my case is a perfect example has an associated cyclitis or irido-cyclitis. A description of this case will be one for the type as reported in the literature.

As usual the patient is a healthy, intelligent child with no apparent manifestations of tuberculosis or syphilis. For a year and a half previous to his consultation the patient had noticed a gradual failure of vision of his right eye, without pain, redness or tenderness. He has always been a healthy child. His parents and family have also been free from tuberculosis or specific diseases and from their stigmata.

Examination: Conjunctiva clear; anterior chamber deeper than normal; abundant "mutton-fat" deposits on posterior surface of cornea; pupil slightly dilated and almost inactive to light; iris clear; tension slightly plus; vitrious cloudy with floating opacities large and small; fundus shows well defined irregular mass with fluffy appearance and dirty white color just above the macula and apparently behind the retinal vessels; considerable oedema of retina surrounding mass; disc ill defined.

Wassermann was negative.

The patient was admitted to the hospital for observation. A two-hourly temperature chart showed a slight afternoon rise. Physical examination was negative, except for posterior cervical glands on both sides, and diseased tonsils and adenoids. Moro and Pirquet reactions were strongly and characteristically positive.

The patient was put on ascending doses of tuberculin. The corneal precipitates disappeared very quickly but after the first injections the vitreus opacities seemed to increase so that the view of the fundus became very indistinct. This was the condition when I first showed him to the section. I have interpreted this as a local reaction to the tuberculin and an additional point to the diagnosis. The eye from that time on steadily improved and after two months was free from most of the opacities and oedema of the retina. I then removed his tonsils and adenoids. The injection of a glycerin extract of the macerated tonsils into a Guinea pig produced no tubercular lesions. The glands of the neck became much smaller after the tonsillectomy and the eye finally subsided to its present quiescent state with the typical choreo-retinal patch of atrophy surrounded by a ring of pigment.

* Read before the Eye, Ear, Nose and Throat Section of the San Francisco County Medical Society, Sept. 26th, 1911.